COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

North Raleigh Hilton
3415 Wake Forest Road • Raleigh, NC 27609

Wednesday, February 15, 2006

Attending:

Commission Members: Pender McElroy (Chairman), Anna Scheyett, Floyd McCullouch, Carl Shantzis, Ed.D., CSAPC, Connie Mele, Dorothy Crawford, Ellen Russell, Emily Moore, George Jones, Judy Lewis, Laura Coker, Lois Batton, Jerry Ratley, Mary Kelly, Mazie Fleetwood, Pearl Finch, Ann Forbes and Ellen Holliman

Commission Members Excused: Buren Harrelson, Fredrica Stell, William Sims, M.D., Marvin Swartz, M.D., Martha Macon, Martha Martinat, Don Stedman, Ph.D. and Clayton Cone

Ex-Officio Committee Members: Bob Hedrick and Joe Donovan

DMH/DD/SAS Staff: Mike Moseley, Steven Hairston, Denise Baker, Michael Lancaster, Flo Stein, Cindy Kornegay, Stacy Silvia-Overcash, Lynn Jones, Jason Reynolds, Starleen Scott Robbins, Marty Lamb, Nathan Swanson, Gerald Peacock and Vanessa Holman

Others: Attorney General Roy Cooper, Greg McLeod, Stephanie Alexander, Christine Trottier and, Joe Chotery

Handouts:

Resolution in honor of Lou Grubb Adkins
Resolution in memory of Ben Aiken
Summary of action by the Rules Committee at its meeting on January 19, 2006

Mailed Packet:

Draft of Minutes from January 18, 2006 Commission for MH/DD/SAS Public Hearing Meeting
Draft of Minutes from January 18, 2006 Advisory Committee Meeting
Draft of Minutes from January 19, 2006 Rules Committee Meeting
Review of Alcohol and Drug Education Traffic Schools 10A NCAC 27G .3800
Intensive Residential Treatment for Children or Adolescents 10A NCAC 27G .1800
Intensive Residential Treatment for Children or Adolescents 10A NCAC 27G .1500
Substance Abuse Intensive Outpatient Program (SAIOP) 10A NCAC 27G .4400
Substance Abuse Comprehensive Outpatient Program (SACOT) 10A NCAC .4500
Rule Reference Materials

Call to Order

Pender McElroy, Chairman, called the meeting to order at 9:41 a.m. Mr. McElroy welcomed all attendees and asked the Commission members, Division staff and all in attendance to introduce themselves.

Mr. McElroy informed the Commission of changes in the agenda to accommodate a presentation by Attorney General Roy Cooper. Mr. McElroy announced that the meeting would proceed as scheduled until the arrival of the Attorney General and that the Commission would resume its discussion of agenda items upon completion of Attorney General Cooper's presentation.

Mr. McElroy identified the Commission members excused from the meeting.

Approval of Minutes

Upon motion, second, and unanimous vote, the Commission approved the minutes of the January 18, 2006 Commission meeting with changes to correctly spell the names of Carl Shantzis, Anna Scheyett, and Martha Martina, and, to change the word "or" to "of" in the second paragraph of the call to order section of the minutes.

Chairman's Report

Mr. McElroy presented for consideration a resolution in honor of Lou Grubb Adkins as follows:

RESOLUTION OF THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

February 15, 2006

WHEREAS, Lou Grubb Adkins was appointed to the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse in 1999; and

WHEREAS, while serving on the Commission from June 1999 until June 2006, she became actively involved in the work of the Advisory Committee; and

WHEREAS, Ms. Adkins was a tireless supporter of housing for the disabled citizens of the State of North Carolina; and

WHEREAS, Ms. Adkins was diligent and fervent in addressing systematic issues facing persons served by the mental health, developmental disabilities and substance abuse service system; and

WHEREAS, the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services using as a backdrop her leadership and passion for housing, has been working during this systems transformation period to continue housing initiatives for persons served by the mental health, developmental disabilities and substance abuse service system; and

WHEREAS, Ms. Adkins' work has encouraged the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services in promoting linkages and the exchange of information between Local Management Entities; and

WHEREAS, the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services and Local Management Entities have worked for better coordination across agency lines, at the state and local level, and to support efforts to speak and act collectively in our approach to an affordable housing system for the benefit of extremely low income persons with disabilities; and

WHEREAS, due to Ms. Adkins' diligence the North Carolina Division Mental Health, Developmental Disabilities and Substance Abuse Services is committed to providing technical assistance and training on ways to maximize existing housing resources and best practices in developing residential and supportive housing services;

NOW, THEREFORE, BE IT RESOLVED, that the Commission expresses its deepest appreciation to Lou Grubb Adkins for her diligent service to the citizens of North Carolina and to the Commission and our best wishes to her in all of her future endeavors.

Upon motion, second, and unanimous vote, the Commission adopted the Resolution in honor Lou Grubb Adkins.

Mr. McElroy presented for consideration a resolution in memory of Ben Warren Aiken as follows:

RESOLUTION OF THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

February 15, 2006

WHEREAS, Ben Warren Aiken faithfully devoted his 37 year career to the people of the state of North Carolina in the area of health and human services; and

WHEREAS, Mr. Aiken served as Business Manager at John Umstead Hospital, Business Manager of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Assistant Secretary of Human Resources, Director of Mental Health, Vice Chair of the Mental Health Study Commission and a member of this Commission; and

WHEREAS, Mr. Aiken also served as Chair of the Board of Directors of the State Employee's Credit Union, Chair of the Board of Trustees for the Methodist Home for Children, and in many other capacities of civic service; and

WHEREAS, Mr. Aiken was the recipient of the Order of the Long Leaf Pine, a high honor in the state of North Carolina;

NOW, THEREFORE, BE IT RESOLVED, that this Commission expresses its appreciation for the long and excellent service provided by Ben Aiken to the North Carolina citizens and especially to North Carolina citizens who are mentally ill, developmentally disabled or suffering from addiction; and, this Commission believes that the exemplary career of Ben Aiken, as well as his depth and warmth as a fellow human being, should always be remembered and serve as an example for all.

Upon motion, second, and unanimous vote, the Commission adopted the Resolution in memory of Ben Warren Aiken.

Mr. McElroy requested a status report on the Level III rules. Cindy Kornegay informed the Commission that the .1700 rules (Residential Treatment Level III) are scheduled to be reviewed by Rules Review Commission (RRC) this Thursday (02/16/06). Based upon preliminary discussions with RRC staff attorney, Joe DeLuca, the Division anticipates approval of the rules at the meeting.

If less than 10 written objections are received by RRC by 5:00pm on Friday, 02/17/06, the rules will become effective on March 1, 2006.

If RRC receives 10 letters of objection to the rules by 5:00pm on Friday, 02/17/06, the rules will be subject to legislative disapproval. Subject to legislative disapproval means, the rules cannot become effective until after the next legislative session begins unless other circumstances apply.

At this point, the Department plans to take the following action if the RRC receives 10 written objections. The Secretary will sign a letter addressed to Judge Julian Mann, Codifier of Rules at the Office of Administrative Hearings. The letter will request that the rules be entered into the Administrative Code as temporary rules per the special provision from the last legislative session. It will then be up to Judge Mann to make a decision about whether or not to enter the rules into the Administrative Code as temporary rules.

If the Codifier does not agree to enter the rules into the Administrative Code, the effective date of the rules will be pending review by the legislature. The next legislative session is scheduled to begin on May 9, 2006. If there is not bill introduced to specifically disapprove the rules before the 31st legislative day, the rules can become effective on the 31st legislative day. A legislative day is one on which either house of the General Assembly convenes. The 31st day of the next session is likely to be the early part of July.

If there is a bill introduced to disapprove the rules before the 31st day, the rules will become effective on the earlier of either the day an unfavorable final action is taken on the bill or the day the session adjourns without ratifying the bill. If a bill disapproving the rules is ratified the rules will not become effective.

Mr. McElroy requested a status report on the Non Medicaid Appeal rules. Cindy Kornegay informed the Commission that the fiscal note was submitted to DHHS Office of Budget and Analysis on February 14, 2006. The fiscal note reflects state and local costs and will require certification by the Office of State Budget

Management; if all required approvals/certifications are obtained, we anticipate publication in the April 3, 2006 NC Register.

Mr. McElroy requested that the minutes reflect that the NC Board of Ethics forwarded a letter stating "In accordance with Section 5(b) of Executive Order One (The Order), we have completed our evaluation of the state of economic interest mentioned above. **We did not find an actual conflict of interest or the potential for conflict of interest** with Commission for MH/DD/SAS member Laura C. Coker."

Mr. McElroy announced that Dr. Stephen Buie, of Asheboro, submitted a letter to Senator Marc Basnight declining appointment to the Commission stating that he was unable to commit to the Commission's schedule. Mr. McElroy requested that Dr. Buie's name be removed from all mailing lists and the Commission's membership roster.

DMH/DD/SAS Director's Report

Division Director Mike Moseley gave an update on the efforts of the DHHS consolidation plan. DHHS informed the legislature that, based upon negotiations and consolidations which have occurred, DMH will not be able to reduce the number of Local Management Entities (LMEs) to twenty (20) as recommended by House Bill 381. As a result, DHHS has considered other options to reduce administrative cost including reducing administrative functions of the LMEs and centralizing Utilization Review functions as well as after-hours Screening, Triage, and Referral processes. No decision has been reached regarding whether DHHS will select this option nor has a decision been made regarding to whom DHHS will refer these functions. Mr. Moseley stated that a decision will be released in writing once it is reached. The Commission requested a copy of the final decision.

Mr. Moseley updated the Commission on the Provider Action Agenda and recommendations. An accelerated focus on the provider system was initiated with the issuance of a web-based provider survey on September 14, 2005. This survey was designed to assist the Division in understanding the challenges facing providers as well as generate suggestions regarding ways in which the Division could assist with the successful transformation of the service system. A Provider Summit convened November 1, 2005. The summit was designed to further evaluate the status of provider stability in system transformation and to determine what actions the Division could take to support transformation. Providers suggested 1) reducing variation in policies and procedures, 2) consolidating LME contract-management responsibilities, 3) standardizing transaction forms and processes across LMEs, and 4) reducing transaction requirements.

The Division's six month agenda (January 1, 2006 through June 30, 2006) will first address infrastructure by establishing a cross-department team to support the Provider Action Agenda. The Division is developing policies to standardize the following processes with dissemination by March 31, 2006 and implementation by July 1, 2006: standardized definition of a "clean claim"; standardized denial codes, standardized policy related to coordination of benefits, and standardized excel claim forms. The division has identified regulations and reporting areas that overlap and

are scheduled for review by the Commission. The Division has also developed strategies for provider improvement as follows: 1) continuing to offer enhanced service definition training, Person Centered Plan (PCP) training, and program specific consultation, 2) providing information to providers about other resources to assist small businesses and 3) offering SAMHSA sponsored confidentiality and ethics training.

Flo Stein presented the status of the Service Definition Communication, Training and Endorsement. New Service Definitions will become effective March 20, 2006. The Division of MH/DD/SAS, the Division of Medical Assistance (DMA) and other entities provide training to enable providers to meet the requirements for endorsement and direct billing. The Division receives a weekly update on the number and type of providers that have been endorsed. LMEs have until February 17, 2006 to notify the Division of the services they will continue to provide. The Division will conduct endorsement visits for LMEs that are continuing to provide services and will consider the availability of other providers in the LME's catchment area to avoid endorsement where too many providers of that service already exist. If the Secretary agrees that the LME should continue providing a particular service, the Division will endorse the LME using the same protocol and standards used for the provider agencies.

An additional part of the reform effort is notifying consumers and families of system changes and of their appeal rights. The Attorney General's (AG) office is working with the Division of Mental Health (DMH) and Division of Medical Assistance (DMA) providing standard appeal guidance for the creation of standardized letters for the appeals process.

Also, the Division has submitted a plan to the Centers for Medicare and Medicaid Services (CMS) under the rehabilitation service option. The service definition for Developmental Therapies, designed to provide services to individuals with developmental disabilities, was not approved by CMS. CMS would only provide services for persons that are developmentally disabled through enrollment in a waiver program. The Division has proposed a plan to reassess consumers in an effort to transition them to services such as, CAP-MR/DD, Community Support, and/or Developmental Therapy. Developmental Therapy is a state-funded service.

Dorothy Crawford asked about providers that do not accept Medicaid or Medicare and questioned how the Division will address this issue. Ms. Stein stated that the Division is only considering endorsement of those agencies that want to be directly enrolled to bill Medicaid.

Dr. Michael Lancaster, Chief of Clinical Policy, DMH, described the collaborative efforts of DMH and the Department of Public Instruction (DPI) to address the needs of children who previously received Community Based Services (CBS) in the school setting. On February 10, 2006, the Division distributed to the LMEs, for dissemination to the Local Education Agencies (LEAs), a workbook and DVD addressing the transition in schools. Currently, many students receive both Case Management and CBS as distinct services. On March 20, 2006, these services will transition to become, a new service, Community Support. As the system transitions, the Division's goal is to ensure the continuity of care for consumers and families. As

provider groups are endorsed to provide Community Support, consumers will be able to choose their preferred provider.

The Division has been in discussion with professional organizations regarding provisionally licensed staff. A provisionally licensed professional will not be able to directly bill Medicaid; however, a provisionally licensed individual will be able to function as a qualified professional while providing enhanced benefits receiving the training required by the licensing board.

Anna Scheyett stated that several students have informed her that non-profit organizations are not hiring provisionally licensed LCSWs (P-LCSWs) because they cannot directly bill to Medicaid. Students do have opportunities as Qualified Professionals; however, the licensing board does not consider the Qualified Professional clinical in nature. If the student does not obtain the requisite number of clinical hours, the student can not be licensed. Dr. Lancaster stated that the licensing boards have made decisions regarding what is or is not clinical and must make a determination as to what they will accept as clinical in the new service definition array. Anna Scheyett requested assistance from the Division in identifying the clinical functions with the new service definition.

Ellen Russell asked about the work the Division is doing with DPI for the 4,500 identified children with developmental disabilities that were receiving CBS services in the school setting. Dr. Lancaster indicated that the Division has worked closely with the DPI to identify the developmentally disabled population as well as those services, which can be provided in the context of the school setting. Flo Stein added that the Division has not ruled out developmental therapies as an option but clarified that it will be managed through utilization review.

Ellen Holliman asked if anyone was going to look at the 16-bed rule for detox and treatment. Ms. Stein stated that the Division will not look at that law because it was a law which existed when the Mental Health system was first created in order to not pay directly for hospitals. Because of problems around the country, this law has been added to each service definition, as a reminder, in the state plan amendment. The Division is trying to look facility by facility to see how much Medicaid is earned and will decide systematically how to replace the Medicaid dollars and maintain capacity. The Division is asking that LMEs keep facilities open until they have contacted Spencer Clark at the Division.

Bob Hedrick asked about the use of associate professionals to perform certain critical job functions, on a transitional basis, until they have the experience to be considered as a qualified professional. These functions would include, such functions as, writing a person-centered plan under the direct supervision of a qualified professional. Dr. Lancaster stated that the definition of person-centered plan clearly identifies who can perform certain functions, but he does not think that an associate professional will be able to perform this function.

Mike Moseley thanked the Division staff present and staff behind the scenes for the incredible job they do and their contributions to the Division's efforts.

Attorney General's Report

Attorney General Roy Cooper was introduced by Chairman Pender McElroy. Mr. Cooper gave a PowerPoint presentation entitled "Methamphetamine & The Meth Lab Prevention Act of 2005: What You Need to Know". Methamphetamine (Meth) is a synthetic nervous system stimulant that can be produced in small clandestine labs. It can be snorted, smoked, injected or ingested. It produces a stronger and longer-lasting "high" than cocaine and is highly addictive. Mr. Cooper, provided details on how Meth destroys human lives. A Meth addict's recovery program is longer than a cocaine/crack addict's program. Mr. Cooper stated that the chemicals used to create Meth are extremely volatile and has become the source of many explosions and fires. Rescue worker have to wear special gear to avoid exposure to the fumes created by Meth Labs. Most of the chemicals used in Meth Labs are disposed of on the grounds of the Meth Labs. The dumpsites from Meth labs are toxic and unlivable years after clean up and a Meth lab creates the threat for ground water contamination. Mr. Cooper stated that the growing Meth lab problem is hurting our children. Since 2004, more than 225 children were removed from homes that were Meth labs and 20% of the Meth Labs discovered had children living in the home. House Bill 248, Methamphetamine Lab Prevention Act of 2005, requires placement of products containing ephedrine and pseudoephedrine behind pharmacy counters, prohibits the purchase of more than 2 packages of products containing these substances in one transaction; and prohibits the purchase of more than 3 packages containing these substances in a 30 day period. Pediatric products and medication in liquid or gel cap form are exempt; however, the Commission has the authority to require that these products meet the same standards as the tablets. House Bill 248 requires the purchaser to 1) present a photo ID, 2) be 18 years old, and 3) sign a logbook.

Judy Lewis asked when the children were removed from homes that were Meth Labs and returned to school whether the child's exposure to the chemicals from the Meth Lab would affect other children in school. Mr. Cooper stated that he believes other children in the schools can be affected by the trace chemicals in the exposed child's clothing, as well as, by behavioral problems that the exposed child may exhibit. The long-term effect is that exposed children will more than likely have a developmental disability.

Anna Scheyett stated that she appreciated Mr. Cooper's proactive leadership on this issue. Ms. Scheyett asked if there was an exception in the legislation for the wholesale clubs like Costco and Sam's club. Greg McLeod, Attorney and staff to Mr. Cooper, stated that the wholesale clubs are bound by the same requirements as a convenience store or pharmacy and law enforcement would have to take action against those who continue to sell in violation of the law. Ms. Scheyett stated that the literature she has received identifies a close link between Meth and HIV and she is wondering if service organizations on infectious disease are receiving good information on how to identify persons abusing Methamphetamine. Mr. Cooper stated he was not aware of that information, but is not surprised given the mental state of individuals on Meth.

Mazie Fleetwood asked what the average age group of Meth users was. Mr. Cooper stated that most users range from young adult up to middle aged, working class, and white, but the demographic is expanding.

Mary Kelly asked if any of the western states have effective treatment programs for this addiction and who one would contact if ephedrine and psuedoephdrine products are found in stores. Mr. Cooper stated that one should notify the store manager first and then contact the local law enforcement office and Joe Chotery would address treatment programs available. Mr. Chotery stated that the Division is using SAMHSA funding to create pilot programs looking at the treatment model, based on the matrix model, which looks at long-term outpatient treatment, which is the only evidence-based model that is successful in treating those with Meth addictions. Mr. Chotery stated that North Carolina will create a video using Mr. Cooper's presentation to educate the community on the problem of Meth in North Carolina.

Mr. McElroy thanked Mr. Cooper and expressed the Commission's gratitude for his attendance and presentation to the Commission. Mr. Cooper expressed his appreciation of the Commission's diligent work in addressing this important issue.

Advisory Committee Report

Steven Hairston, Chief, Operations Support Section, DMH, presented the report on the Advisory Committee meeting which convened January 18, 2006. Mr. Hairston stated that there was considerable discussion to determine what issues the committee will address during the year. The committee decided to concentrate on four areas:

(1) Raising or heightening workforce awareness,
(2) Reviewing the rules regarding training,
(3) Articulating systems functions and policy clarity between:
    (a) The Division,
    (b) The AP/LME,
    (c) Providers, and
    (d) Stakeholders,
(4) Analyzing statistical data regarding labor market information including
    (a) What does the workforce look like now,
    (b) What will it look like, and
    (c) How we can better prepare ourselves to meet the workforce needs.

At the conclusion of that meeting and in continuing discussions over the last 30 days, Marvin Swartz and the leadership of the Division have decided to develop three sub-committees. The sub-committees are as follows:

(1) Governance - This sub-committee will work to articulate system functions and policy clarity between Division, LME and providers. It will also develop strategies to implement and raise awareness of the workforce development needs of the state.

(2) Workforce/ labor market information – This sub-committee is charged with performing an analysis of statistical data related to the workforce of North Carolina. This group will study job trends and populations in order to make

projections about what the needs will be over the next 10-15 years. This sub committee will also identify what staff will be available to meet those needs.

(3) Direct support care workers- This sub-committee will work in conjunction with the NC Council on Developmental Disabilities. The council has a strong interest in direct care workers and currently has an initiative underway regarding workforce development.

The advisory committee decided that their next steps include assigning additional members from the Commission to the sub-committees. At the January 18, 2006 meeting members of the Commission, identified areas of interest and the committee on which they would like to serve. The advisory committee is requesting additional Commission members to serve on the sub-committees. The mission of each sub-committee will be available once the leadership at the Division, along with Marvin Swartz, outline each task of the sub-committees.

Rules Committee Report:

Floyd McCulloch, Chairperson, Rules Committee of the Commission for MH/DD/SAS, presented the report from the Rules Committee meeting, which convened January 19, 2006. The Rules Committee reviewed proposed rule changes as follows:

Alcohol and Drug Traffic Schools (ADETS) - The purpose of the proposed changes is to amend rules governing the number of instructional program hours and the class size for ADETS schools. The Rules Committee unanimously approved sending the proposed amendment forward and recommended approval for publication by the Commission.

Mr. McElroy asked for a motion to approve the rules for Alcohol and Drug Traffic Schools 10A NCAC 27G .3800.

Upon motion, second, and unanimous vote the Commission approved for publication the proposed amendment of 10A NCAC 27G .3803 for Alcohol and Drug Traffic Schools.

Intensive Residential Treatment for Children and Adolescents - The proposed adoptions are necessary to establish a new licensure category for intensive residential treatment for children and adolescents. There were no comments received for these proposed rules during the public comment period. The Rules Committee recommended changes to prevent inconsistencies between the .1700 and the .1800 rules. The recommended changes were:

- 10A NCAC 27G .1801 (c) change “principle” to “primary” to have the same language as 10A NCAC .1701(c) of the residential treatment rules.
- 10A NCAC 27G .1804(a) delete the requirement of one direct care staff being present in the facility when there are no clients present.
- 10A NCAC 27G .1804(b) amend to read the same as 10A NCAC 27G .1704(b) of the residential treatment rules.

- 10A NCAC 27G .1804(d) (1) amended to require three direct staff to be present for up to six children or adolescents.

The Rules Committee unanimously approved these changes and recommended adoption by the full Commission.

Mr. McElroy asked for a motion to adopt the rules for Intensive Residential Treatment for Children and Adolescents 10A NCAC 27G .1800

Upon motion, second, and unanimous vote the Commission adopted 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents.

The Rules Committee also reviewed the proposed repeal of 10A NCAC 27G .1500. The proposed repeal is necessary because 10A NCAC .1800 will replace this Section to establish a new licensure category for intensive residential treatment for children and adolescents. The Rules Committee unanimously approved sending the proposed repeals forward and recommended approval for publication by the Commission.

Mr. McElroy asked for a motion to approve publication for repeal of the rules for Intensive Residential Treatment for Children and Adolescents 10A NCAC 27G .1500.

Upon motion, second, and unanimous vote the Commission approved publication for repeal of 10A NCAC 27G .1500.

Substance Abuse Intensive Outpatient Program (SAIOP) and Substance Abuse Comprehensive Outpatient Treatment (SACOT) - The proposed rules are necessary to establish licensure categories for these services. There were no comments received on these proposed rules during the public comment period. The Rules Committee recommended changes as follows:

- 10A NCAC 27G .4401(a) and .4501(a) change the word “principle” to “primary” to remain consistent with changes made to the residential treatment rules.
- 10A NCAC 27G .4403(f) and .4503(f) amend to provide clarity concerning telephonic and face-to-face crisis and emergency response requirements.

The Rules Committee unanimously approved these changes and recommended adoption by the Commission.

Mr. McElroy asked for a motion to approve the rules for Substance Abuse Intensive Outpatient Treatment 10A NCAC 27G .4400 and Substance Abuse Comprehensive Outpatient Treatment 10A NCAC 27G .4500.

Upon motion, second, and unanimous vote the Commission adopted 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Treatment and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment.

Mr. McElroy informed the Commission that effective with this meeting, all rules adopted, revised or repealed will be attached verbatim to the minutes of the meeting where the action was taken.

There was no public comment.

There being no further business the meeting adjourned at 2:13p.m.

SECTION .1800 – INTENSIVE RESIDENTIAL TREATMENT FOR CHILDREN OR ADOLESCENTS

10A NCAC 27G .1801 is adopted as published in NC Register Volume 20 Issue 9 Pages 687-689 with changes as follows:

10A NCAC 27G .1801 SCOPE

(a) An intensive residential treatment facility is one that is a 24-hour residential facility that provides a structured living environment within a system of care approach for children or adolescents whose needs require more intensive treatment and supervision than would be available in a residential treatment staff secure facility.

(b) It shall not be the primary residence of an individual who is not a client of the facility.

(c) The population served shall be children or adolescents who have a ~~principal~~ primary diagnosis of mental illness, severe emotional and behavioral disorders or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for acute inpatient psychiatric services.

(d) The children or adolescents served shall require the following:

(1) removal from home to an intensive integrated treatment setting; and

(2) treatment in a locked setting.

(e) Services shall be designed to:

(1) assist in the development of symptom and behavior management skills;

(2) include intensive, frequent and pre-planned crisis management;

(3) provide containment and safety from potentially harmful or destructive behaviors;

(4) promote involvement in regular productive activity, such as school or work; and

(5) support the child or adolescent in gaining the skills needed for reintegration into community living.

(f) The intensive residential treatment facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.

History Note: Authority G.S. 122C-26; 143B-147;
Eff. April 1, 2006.

10A NCAC 27G .1804 is adopted as published in NC Register Volume 20 Issue 9 Pages 687-689 with changes as follows:

10A NCAC 27G .1804 MINIMUM STAFFING REQUIREMENTS

~~(a) One direct care staff is required to be present in the facility at all times when children or adolescents are away from the facility.~~

~~(b) An additional on-call direct care staff shall be readily available by telephone or page and able to reach the facility within 30 minutes of the call or page.~~

(a) A Qualified Professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times.

(b) ~~(c)~~ If children or adolescents are cared for in separate units/buildings, the minimum staffing numbers shall apply to each unit/building.

(c) ~~(d)~~ The minimum number of direct care staff required when children or adolescents are present and awake is as follows:

(1) three direct care staff shall be present for ~~five or~~ up to six children or adolescents;

(2) four direct care staff shall be present for seven, eight or nine children or adolescents; and

(3) five direct care staff shall be present for 10, 11 or 12 children or adolescents.

(d) ~~(e)~~ During child or adolescent sleep hours three direct care staff be present of which two shall be awake and the third may be asleep.

~~(f) Direct care staff shall meet the Provider Requirement and Supervision standards as set forth in the Division of Medical Assistance Clinical Policy Number 8D-2, Intensive Residential Treatment Services, including subsequent amendments and editions. A copy of Clinical Policy 8D-2 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/.~~

(e) ~~(g)~~ In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(e) of this Rule, more direct care staff may be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan.

History Note: *Authority G.S. 122C-26; 143B-147;*
Eff. April 1, 2006.

SECTION .1500 - INTENSIVE RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS WHO ARE EMOTIONALLY DISTURBED OR WHO HAVE A MENTAL ILLNESS

10A NCAC 27G .1501 SCOPE

~~(a) An intensive residential treatment facility for children and adolescents with emotional or behavioral disturbances or both is a short-term, 24-hour residential program providing a structured living environment for children and adolescents who do not meet criteria for acute inpatient care and whose needs require more intensive treatment and supervision than would be available in a community residential treatment facility. Intensive residential treatment is not intended to be a long-term residential placement for children and adolescents who must be permanently removed from their homes.~~

~~(b) Services shall be designed to address the functioning level of the child and adolescent and include training in self-control, communication skills, social skills, and behavioral skills necessary to move to a community setting. Services may also include monitoring medication trials.~~

~~(c) The target populations to be served in an intensive residential setting are children and adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment. Intensive residential treatment is targeted toward children and adolescents who no longer meet criteria for inpatient psychiatric services and need a step-down placement prior to community placement, or those who have been placed in a community residential setting and need a more intensive treatment program.~~

~~(d) Treatment, services and discharge plans by intensive residential treatment facilities shall be coordinated with other individuals and agencies within the client=s local system of care.~~

History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.

10A NCAC 27G .1502 STAFF

~~(a) Each facility shall have a director who has a minimum of three years experience in child or adolescent services and who has educational preparation in administration, education, social work, nursing, psychology or a related field.~~

~~(b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit.~~

~~(c) When two or more clients are in the facility, an emergency on-call staff shall be readily available by telephone or page and able to reach the facility within 30 minutes.~~

~~(d) If the facility is hospital based, staff shall be specifically assigned to this program, with responsibilities clearly separate from those performed on an acute medical unit or other residential units.~~

~~(e) Each child or adolescent admitted to a facility shall have a weekly consultation with a psychiatrist to review medications and to ensure that the psychiatrist is involved in the development of a transition plan to a less restrictive setting or to a more acute inpatient setting.~~

~~(f) Clinical consultation shall be provided weekly by a qualified mental health professional.~~

~~(g) Clinical consultation with staff from the responsible area program shall occur weekly in order to assist with the development of a treatment plan in a community-based setting.~~

History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.

10A NCAC 27G .1503 OPERATIONS

~~(a) Capacity. Each unit shall serve no more than a total of 12 persons. If the facility has more than one residential unit, the capacity of each unit shall be limited to 12 children and adolescents. Any facility licensed or approved to provide these services for a greater capacity as of the effective date of these Rules shall continue to provide services at no more than the licensed or approved capacity.~~

~~(b) Residential units. Each residential unit shall be administered, staffed, and located to function separately from all other residential units in the facility.~~

~~(c) Length Of Stay. Efforts for discharge to a less restrictive community residential setting shall be documented from the date of admission.~~

~~(d) Hours Of Operation. Each facility shall operate as a 24-hour facility at least 50 weeks per year.~~

~~(e) Family Involvement. Family members or other responsible adults shall be involved in the development and implementation of treatment plans in order to assure a smooth transition to a less restrictive setting.~~

~~(f) Education. Children and adolescents residing in an intensive residential treatment facility shall receive appropriate educational services, either through a facility-based school, "home-based" services, through a day treatment program or other services consistent with federal and State law. Transition to a public school setting shall be part of the treatment plan.~~

~~(g) Clothing. Each child or adolescent shall have his own clothing and shall have training and help in its selection and care.~~

~~(h) Personal Belongings. Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan.~~

~~(i) Transition Planning. Representatives from agencies and institutions serving a child or adolescent shall meet at admission and 30 days prior to discharge in order to assure that a plan for transition to a lesser restrictive residential setting is in place. Family members or guardians or both of the child shall be present at these meetings.~~

History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.

10A NCAC 27G .1504 PHYSICAL PLANT

~~(a) The facility may be hospital based. The units shall be self-contained and separate from acute medical units and other residential units in a clearly defined physical setting.~~

~~(b) Beds may not be shared with an acute medical unit.~~

~~(c) Subject to building and fire codes, the facility may be locked to prevent both entry and exit.~~

History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.

SECTION .4400 – SUBSTANCE ABUSE INTENSIVE OUTPATIENT PROGRAM

10 NCAC 27G .4401 is adopted as published in the NC Register Volume 20 Issue 10 with changes as follows

10A NCAC 27G .4401 SCOPE

(a) A substance abuse intensive outpatient program (SAIOP) is one that provides structured individual and group addiction treatment and services that are provided in an outpatient setting designed to assist adults or adolescents with a ~~principle~~ primary substance-related diagnosis to begin recovery and learn skills for recovery maintenance.

(b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse and other homogenous groups.

(c) Each SAIOP shall have a structured program, which includes the following services:

(1) individual counseling;

(2) group counseling;

(3) family counseling;

(4) strategies for relapse prevention, which incorporate community and social supports;

(5) life skills;

(6) crisis contingency planning;

(7) disease management;

(8) service coordination activities; and

(9) biochemical assays to identify recent drug use (e.g. urine drug screens).

History Note: Authority G..S. 122C-26; 143B-147;
Eff. April 1, 2006.

10 NCAC 27G .4403 is adopted as published in the NC Register Volume 20 Issue 10 Pages 736-737with changes as follows:

10A NCAC 27G .4403 OPERATIONS

(a) A SAIOP shall operate in a setting separate from the client's residence.

(b) Each SAIOP shall operate at least three hours per day, at least three days per week with a maximum of two days between offered services.

(c) A SAIOP ~~should~~ shall provide services a maximum of 19 hours for each client.

(d) Each SAIOP shall provide services a minimum of nine hours per week for each client.

(e) Group counseling shall be provided each day program services are offered.

(f) ~~Crisis services shall be available by telephone 24 hours a day, 7 days a week when the treatment program is not in session.~~ Each SAIOP shall develop and implement written policies to carry out crisis response for their clients on a face to face and telephonic basis 24 hours a day, seven days a week, which shall include at a minimum the capcity for face to face emergency response within two hours.

(g) Before discharge, the program shall complete a discharge plan and refer each client who has completed services to the level of treatment or rehabilitation as specified in the treatment plan.

History Note: Authority G..S. 122C-26; 143B-147;
Eff. April 1, 2006.

SECTION .4500 – SUBSTANCE ABUSE COMPREHENSIVE OUTPATIENT TREATMENT PROGRAM

10 NCAC 27G .4501 is adopted as published in the NC Register Volume 20 Issue 10 Pages 737-738 with changes as follows:

10A NCAC 27G .4501 SCOPE

(a) A substance abuse comprehensive outpatient treatment program (SACOT) is one that provides a multi-faceted approach to treatment in an outpatient setting for adults with a ~~principle~~ primary substance-related diagnosis who require structure and support to achieve and sustain recovery.

(b) Treatment support activities may be adapted or specifically designed for persons with physical disabilities, co-occurring disorders including mental illness or developmental disabilities, pregnant women, chronic relapse, and other homogenous groups

(c) SACOT shall have a structured program, which includes the following services:

(1) individual counseling;

(2) group counseling;

(3) family counseling;

(4) strategies for relapse prevention to include community; and social support systems in treatment;

(5) life skills;

(6) crisis contingency planning;

(7) disease management;

(8) service coordination activities; and

(9) biochemical assays to identify recent drug use (e.g. urine drug screens).

(d) The treatment activities specified in Paragraph (c) of this Rule shall emphasize with the following:

(1) reduction in use and abuse of substances or continued abstinence;

(2) the understanding of addictive disease;

(3) development of social support network and necessary lifestyle changes;

(4) educational skills;

(5) vocational skills leading to work activity by reducing substance abuse as a barrier to employment;

(6) social and interpersonal skills;

(7) improved family functioning;

(8) the negative consequences of substance abuse; and

(9) continued commitment to recovery and maintenance program.

History Note: Authority G..S. 122C-26; 143B-147;

10 NCAC 27G .4503 is adopted as published in the NC Register Volume 20 Issue 10 Pages 737-738 with changes as follows:

10A NCAC 27G .4503 OPERATIONS

(a) A SACOT shall operate in a setting separate from the client's residence.

(b) Each SACOT shall provide services a minimum of 20 hours per week.

(c) Each SACOT shall operate at least four hours per day, at least five days per week with a maximum of two days between offered services.

(d) Each SACOT shall provide a structured program of services in the amounts, frequencies and intensities specified in each client's treatment plan.

(e) Group counseling shall be provided each day program services are offered.

(f) ~~Crisis services shall be available by telephone 24 hours a day, 7 days a week when the treatment program is not in session~~. Each SACOT shall develop and implement written policies to carry out crisis response for their clients on a face to face and telephonic basis 24 hours a day, seven days a week, which shall include at a minimum the capcity for face to face emergency response within two hours.

(g) Psychiatric consultation shall be available as needed.

(h) Before discharge, the program shall complete a discharge plan and refer each client who has completed services to the level of treatment or rehabilitation as specified in the treatment plan.

History Note: Authority G..S. 122C-26; 143B-147;
Eff. April 1, 2006.